| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced annual survey was conducted at this facility from August 10, 2011 through August 17, 2011. The deficiencies contained in this report are based on observations, staff interviews, review of clinical records, facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was 22. The stage 2 survey sample totaled 26 residents. | F 000 | | |
| F 159 SS=C | 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS<br><br>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.<br><br>The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)<br><br>The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br><br>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. | F 159 | **1. Corrective Action – F159**<br><br>F159 – The resident was not adversely affected by this practice.<br><br>**2. Identification of other residents**<br><br>-Authorization forms established and mailed to residents/POA's with existing resident petty cash balance to be filed with the resident's petty cash file. by 9/1/11<br><br>-Quarterly reports mailed to residents/POA's with authorization forms by Social Service Director to be kept on file.<br><br>**3. System Implemented**<br><br>-Written Policies to include:<br>Residents Petty Cash Funds<br>Quarterly Accounting of Residents Funds<br>by 9/1/11<br><br>Policy entitled "Residents Petty Cash Funds" was changed to reflect that the residents have access to their petty cash funds Monday – Sunday 8:00am-3:30pm. by 9/1/11<br><br>Quarterly Accounting of Residents Funds policy established. | 8/31/2011<br><br>8/31/2011<br><br>8/21/2011<br><br>8/21/2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marion Taggart, NHA — TITLE: Executive Director — (X6) DATE: 09/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Marion Taggart, NHA — 9/30/2011



Executive Director

(Revised addendum)

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| F 159 | Continued From page 1<br><br>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br><br>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.<br><br>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of residents' personal funds documentation and staff interviews, it was determined that the facility failed to maintain written policies/procedures for the handling and management of the residents personal petty fund accounts, they failed to have written authorization for each resident's petty cash fund account for the facility to manage the residents' personal funds, they failed to provide a system where residents had access to their personal funds or cash, on an ongoing basis including weekends, and the facility failed to provide quarterly account statements to residents to make them aware of their balances in their petty cash accounts.<br>Findings include: | F 159 | **F159, Continue**<br><br>**3. System Implemented, Continue**<br><br>-Authorization forms will be available to administrative personnel. by 9/1/11<br><br>-Quarterly statements will be sent out on a quarterly basis to all residents/POA's who have or had any funds in their account for that quarter by the Social Service Director. Copies will be kept on file. by 9/1/11<br><br>**4. Quality Assurance Monitoring**<br><br>Quarterly accounting of residents funds will be reported to the Quality Assurance committee for monitoring by the Social Service Director. | |

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| F 159 | Continued From page 2<br>Review of the residents' petty cash fund accounts with E10 (Assistant Controller) on 8/12/11 revealed that the residents had non-interest bearing petty cash accounts. The balance total was approximately $350. E10 stated that the facility kept a petty cash account in which each resident could keep no more than $50. E10 stated that she was not aware of policies or procedures related to the management, or accounting of the residents' petty cash funds, and she did not send or give residents, or their POA's quarterly statements on their petty cash account balances.<br><br>Review of three (out of twelve) residents' petty cash fund accounts were done with E 11 (Receptionist/Secretary) . In an interview with E11 on 8/12/11, E11 stated that she managed the petty cash funds for the residents. E11 confirmed that when residents or their POA's, made requests for funds to be taken out of the petty cash fund account, she tallied the amounts and maintained a running balance on a form she kept for each resident. E11 confirmed she was never given a procedure or policy with regard to the management<br>of the residents' petty cash funds, had never seen one, she did not get written authorization to manage the residents' accounts (only verbal authorization), and she stated that the social service director handled the authorization piece of the process. E11 confirmed she did not send quarterly statements to the residents to let them know the balances in their petty cash accounts.<br><br>On 8/12/11, in an interview with E15 (Social Services Director), she confirmed she did not send quarterly statements to the residents to let | F 159 | | |

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| F 159 | Continued From page 3<br>them know how much money they had in their petty cash account, and did not get written authorization from the residents's POA, or residents, prior to managing their petty cash funds. She confirmed she had no procedure for the management of petty cash funds.<br><br>On 8/15/11, a copy of a new procedure, entitled "Personal Funds Accounts (PFA)", developed on 8/12/11, was provided to the surveyor. This procedure documented that residents could only access their personal funds account during the hours of 8:00 AM to 3:30 PM, Monday - Friday. In an interview with E11 on 8/15/11, she revealed that residents had no access to their funds on the weekends or past 3:30 PM as she was the only one with access to the key to the cabinets where the funds were stored. E11 stated that if residents wanted money out of their petty cash accounts, they needed to ask for the money on Friday for the weekend.<br><br>Interview with E10 (Assistant Controller) on 8/16/11 acknowledged this finding.<br><br>Review of the admission packet revealed a form entitled "Resident Authorization for Management of Personal Funds". The packet also revealed a resident admission agreement which addressed funds, entitled "Resident Funds", and it documented that "written authorization was required for residents to deposit personal funds with the facility". | F 159 | | |
| F 241 SS=E | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or | F 241 | | |

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| F 241 | Continued From page 4<br>enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined that the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality during the medication pass observation for 6 residents (R1, R5, R10, R16, R21, and R34) out of 10 residents observed. Findings include:<br><br>On 8/15/11, during the medication pass observation, E5 (RN) was observed entering the rooms of R1, R5, R10, R16, R21 and R34 without knocking or asking permission to enter.<br><br>On 8/15/11, E5 confirmed the findings. | F 241 | F 241 R#1, R5, R10, R16, R21 and R34<br>1. Corrective Action<br>Absence of knocking on residents door requesting permission to enter did not occur; no resident adversely affected as observed thereafter.<br>2. Identification of other Residents<br>All residents have the potential to be affected.<br>3. Systems Implemented<br>In-services on Dignity and Resident's Rights are initiated for education to assure all staff knock on the residents' doors to ask permission to enter and identify themselves initiated and completed by 9/30/11.<br>4. Quality Assurance Monitoring<br>Continued monitoring for staff compliance will be audited at random times weekly to include staff when on the Nursing unit by the ADON/ or Designee and reported at the Quarterly QI. | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to | F 309 | | |

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| F 309 | Continued From page 5<br>ensure that each resident received and the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 (R23) out of 26 Stage 2 residents. The facility failed to have a system that consistently and accurately monitored R23's fluid restriction. The facility failed to follow R23's physician order of 1500 ml (milliliters) of fluids per day, 1200 ml for dietary and 300 ml for nursing. Findings include:<br><br>The facility policy/procedure for Intake and Output Measurement, dated 1/07, stated, "The following residents require measurement and general documentation guidelines of intake and output every eight hours. Including a 24 hour total and weekly evaluation...5. All residents with an order for fluid restriction or encouragement. (intake required). Procedure... 7. The intake and output are to be totaled and recorded on the permanent intake and output record every shift. 8. Intake and output are totaled every twenty-four hours. 9. The intake and output is to be evaluated weekly to determine adequacy. If not adequate or if output is more than intake, the physician is to be notified and corrective action taken."<br><br>R23 had diagnoses of end stage renal disease (ESRD), hypertension and diabetes. Per the physician order sheet (POS), dated 7/5/11, R23's diet order included a 1500 ml fluid restriction -1200 ml dietary, 300 ml nursing, and carbohydrate controlled, low potassium meals. Review of the physician progress note, dated 8/9/11, revealed that R23's physician did not address any fluid concerns during that visit. | F 309 | F 309 R#23<br>1. Corrective Action<br>Failure to have system in place for accurately monitoring fluid restriction had no affect on this resident as evidenced by no change in condition. initiated 9/1/11<br>2. Identification of other Residents<br>No other residents were affected; there are no other residents with fluid restrictions at this time.<br>3. Systems Implemented<br>Policy and Procedure for fluid restrictions implemented immediately to include dialysis residents and assure communication by use of a developed Dialysis Communication form and I&O form to assure compliance including fluids at meals, dialysis, medication times and prn will be in-serviced to all nursing staff by 9/30/11.<br>4. Quality Assurance Monitoring<br>Audits will be maintained by the Unit manager/ designee weekly for accuracy to include documented fluids on the MARs, I&Os, and the return of Dialysis Communication forms to the resident's record to assure compliance of ordered fluid restrictions maintained. | |

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| F 309 | Continued From page 6 | F 309 | | |

The care plan entitled, At Risk for Alteration in Nutrition due to ESRD on HD (hemodialysis), last revised 8/9/11, had goals of no significant weight change through the next review and adequate fluid status. Interventions included, "Provide diet per MD orders, monitor meal intakes daily, monitor weight, monitor labs, education on renal diet parameters..."

On 8/15/11 at 7:45 AM, R23, an alert and oriented resident, was observed during the breakfast meal. R23's diet slip stated, 1500 ml, carb controlled, and low potassium diet. R23 had eggs, scrapple, hash browns, assorted melon cubes and oatmeal with 4 oz (120 ml) apple juice and 8 oz (240 ml) black coffee for fluids which was consistent with R23's diet order.

Review of the 6/11 handwritten, untotaled Intake Record for R23 revealed the fluids per day ranged from 60 ml's to 1080 ml's/day. Review of the Fluids Consumed computerized sheet for 6/11 rarely equaled the handwritten intake sheet. The range on the Fluids Consumed sheet was 0 ml - 1320 ml's.

Review of the 7/11 handwritten, untotaled Intake Record for R23 revealed the fluids per day ranged from 0 ml to 1000 ml's/day. Review of the Fluids Consumed computerized sheet for 7/11 did not equal the handwritten intake sheet with the exception of 6/21/11 of 420 ml's/day. The range on the Fluids Consumed sheet was 300 ml's - 1440 ml's.

Review of the handwritten, untotaled Intake Record for R23 from 8/1/11 - 8/14/11 revealed

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| F 309 | Continued From page 7<br>the fluids per day ranged from 0 ml to 1020ml's/day. Review of the Fluids Consumed computerized sheet for the same time interval did not equal the handwritten intake sheet.The range on the Fluids Consumed sheet from 8/1/11-8/14/11 was 240ml - 1140 ml/day.<br><br>Review of the Medication Administration Record (MAR) from 6/11 - 8/11 revealed that nursing did not record fluid amounts on the 6/11-8/11 MARs, although allotted 300 ml's.<br><br>On 8/15/11, in an interview with E3 (ADON), she confirmed the findings that R23's physician order of 1500 ml fluid restriction was not being followed. The resident was not receiving 1500 ml/day according to the Intake records reviewed. E3 confirmed that the handwritten Intake Record sheets were inconsistent with the computerized Fluids Consumed reports. E3 also confirmed that the MAR did not have any nursing fluids recorded.<br><br>The facility failed to have evidence of consistent monitoring of the resident's intake in order to maintain the R23's physician order of 1500 ml fluid restriction - 1200 ml dietary, 300 ml nursing. Additionally, the facility failed to follow their policy and procedure for Intake as noted above. | F 309 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. . | F 318 | | |

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| F 318 | Continued From page 8 | F 318 | F 318 R#30<br>1. Corrective Action<br>Resident was not affected as evidenced by no decline when measured contractures recently performed by Rehab. from baseline. (R30 added 9/12/11)<br>2. Identification of other Residents<br>All residents have the potential to be affected.<br>3. Systems Implemented<br>All residents with contractures are measured for a base line and ROM assessments are done by Rehab. with the findings documented and communicated to the restorative nurse/ ADON for implementation of recommended interventions and care planned for ongoing reviews quarterly by screenings per Rehab. If any changes noted it will be followed up by an evaluation per Rehab. or recommendation to be discontinued with supportive documentation on the residents record will be reviewed by the ADON/ Restorative Nurse. (R30 added on 9/12/11)<br>4. Quality Assurance Monitoring<br>Audits for restorative and ROM interventions will be reviewed and appropriate changes implemented for compliance documented on the residents care plan to assure maintenance of functional benefits for all residents requiring this service The residents will be reviewed on a monthly basis by the ADON/designee with the Rehab. Director, and the Restorative CNA. All by 9/30/11 | |

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of other documentation as indicated and interview, it was determined that the facility failed to ensure that 1 (R30) resident with a limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion out of 26 stage 2 residents sampled. According to a May 2011 care plan, R30, a hospice resident with multiple contractures, was to have a restorative plan of care developed so as not to have further decline in her contractures. The restorative plan was not developed or implemented. Findings include:

R30 was admitted to the facility in 2007. Diagnoses included: old CVA (stroke) and end stage senile dementia with psychotic features. R30 requires total care by facility staff for all activities of daily living and was on hospice.

Review of contracture measurements done on 5/21 (year confirmed to be 2011 with E21/PT assistant as there was no year listed) revealed that R30 had contractures of the left hand, bilateral hips, right knee, right foot, left shoulder and left elbow. Decreased ROM (range of motion) was noted in the left knee, left foot, neck, right shoulder and right elbow.

A Therapy Weekly Progress Report, dated 11/9/10, stated, "There is not significant change in ROM or decreased contracture: That is why

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plan to D/C (discontinue) pt. (patient) this week... Barriers to progress: L knee fx (fracture), R knee contracture. Pain 8/10 during stretching." The Plan of Treatment for Outpatient Rehabilitation, dated 11/12/10 stated, "lack of progress pt. D/C from P.T. (physical therapy) services."

Review of the facility care plan, dated 5/5/11 for actual contractures listed goals to prevent contractures and to prevent worsening of existing contractures. Interventions included: "... 3. OT (occupational therapy) to develop a restorative or rehabilitative plan for resident to lessen or prevent contractures. 4. OT to educate and assist nursing staff to carry out the developed plan of care...".

R30's facility care plan for contractures, dated 8/4/11, listed the goal "ROM or contracture will improve or experience/exhibit no worsening in observable or measurable by next review in 90 days." Interventions included: "Maintain joints in neutral position. promote good posture and proper alignment at all times. Consult with therapist, PT/OT prn (as needed). Rehab Dept will perform contracture measurements annually (sic)."

Review of the Interim Plan of Care for facility nurses aides had a check by ROM, however, active versus passive ROM was not indicated nor was which extremity was to have ROM. Interventions/tasks performed by facility aides from 7/1/11 to 8/15/11 lacked ROM.

Review of the hospice initial assessment, dated 12/2/10, stated, "...contractures noted to BLUE and BLLE (bilateral upper and lower extremities)

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..."

Review of the hospice aide care plan, dated 7/27/11, revealed that R30 received hospice aide services 5 times per week to include feeding and total care. Functional limitations included bilateral upper and lower extremity contractures. There were no services such as ROM or splints listed to lessen or prevent worsening of R30's existing contractures.

Review of the hospice care plan, dated 8/9/11, also listed contracture as a functional limitation, however, there was no care plan or interventions for R30's contractures.

Review of the clinical record lacked a restorative or rehabilitative plan for R30's contractures as indicated in the 5/5/11 care plan.

Observations of R30 on 8/15 and 8/16/11 revealed multiple contractures and no splints in place.

E21 (PT assistant) was interviewed on 8/16/11. She stated that OT services were discontinued on 4/19/10. E21 was unable to find a restorative or rehabilitation plan done by OT as stated in the 5/5/11 care plan. She stated that the new OT group had only been in the facility for about a month.

E14 (OT) was interviewed on 8/16/11. She called hospice to see why R30 was not receiving treatment for contractures. E14 was unable to find a restorative or rehabilitation plan as stated in the 5/5/11 care plan.

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| MASONIC HOME OF DELAWARE | 4800 LANCASTER PIKE WILMINGTON, DE 19807 |

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| F 318 | Continued From page 11<br>E3 (Assistant Director of Nursing) was interviewed on 8/16/11. E3 confirmed that R30 was not on the list for restorative services at this time or since she began employment here about a month ago.<br><br>A fax was received from the facility after exit on 8/17/11. The hospice interdisciplinary progress note, dated 8/16/11, stated, "...admission to... hospice 11/23/10...exhibits hand & leg contractures which have been present since admission. Hand contractures, upon observation, have not changed or deteriorated significantly since admission... No rehabilitative services indicated."<br><br>The facility failed to develop a restorative or rehabilitative care plan as stated in R30's 5/5/11 care plan and she continues to not receive services or treatment such as ROM or splints to lessen or prevent worsening of her existing contractures. | F 318 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, it was determined that the facility failed to maintain | F 323 | | |

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| F 323 | Continued From page 12<br>the environment free from accidents hazards, as evidenced by accessible hazardous chemicals in unlocked rooms and cabinets, accessible high voltage electrical panels in an unlocked room, a radio in a resident SPA room under a sink (that flushes urinals) connected to an ungrounded outlet, unsecured oxygen tanks in the physical therapy room, extension cords on floors posing a tripping hazard, non-functional facility alarmed fire doors, a Wanderguard bracelet for R22 that was nonfunctional, and lack of a documented system to test the function of the armed doors. Findings include: | F 323 | | |

1 A. An observation of R23 and R29's room on 8/11/11 at 10:21 AM revealed an electric extension cord on the floor that posed a potential tripping hazard. The electric cord was in the walking space of the floor and had a circular loop in the center of the floor in front of the closets. In interviews with E9 (CNA) and E6 (Nurse) on 8/11/11, they confirmed the finding.

18. An observation of R34's room during the environmental tour on 8/15/11 at 10:48 AM with E16 (Maintenance director) revealed an electric cord on the floor between the bed and the TV which posed a potential tripping hazard for R34. In an interview with E16 on 8/15/11, he acknowledged this finding.

2. Observations of the facility Health Care (HC)hallway on 8/10/11 at 8:50 AM revealed an open, unlocked cleaning cart was unattended with chemicals that were accessible to residents. The cart did not have closed and locked storage.

3. Observations of the first floor dining room area

1. All electric cords have been replaced with power strips (8/17/11)
2. All power strips will be secure to the wall to avoid tripping. (8/17/11)
3. Policies & procedures are in place eliminating the use of electric cords. by 9/30/11
4. Tour around the building to see that no other electric cords are used.

1. Replace all housekeeping carts with new locking ones
2. Housekeeping will lock all carts when working in rooms
3. Policies & Procedures are in place mandating when and why all carts should be locked.
4. Daily check will be made to ensure carts are locked.

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| F 323 | Continued From page 13<br>kitchenette on 8/11/11 at 9:00 AM revealed chemicals, including one (1) open 24 fl oz bottle of liquid sanitizer, one (1) open 24 fl oz bottle of liquid all purpose cleaner and degreaser, one (1) open 64 fl oz bottle of Miracle Bubbles, and one (1) open 25 fl oz bottle of Ivory dish soap. The chemicals were accessible in the unlocked, under the sink, cabinet.<br><br>4. Observation of the facility's first floor clean linen room on 8/10/11 at 8:45 AM revealed the door was open. Under the sink, there were three (3) 8 fl oz open bottles of nail polish remover in an unlocked cabinet.<br><br>5. Observations of the resident common SPA room on 8/11/11 at approximately 10:00 AM and 1 :00 PM revealed a radio, and a Febreeze machine, sitting on a shelf above the sink flusher of urinal equipment. Both were plugged into an ungrounded electric outlet.<br><br>Observations of the resident common SPA room With E15 (Social Services Director) on 8/10/11 at 1:45 PM revealed the radio and the Febreeze machine were still in the same position as observed earlier. E15 confirmed the finding and stated she would contact maintenance. In an interview with E16 (Maintenance Director) on 18/10/11 at 3:00 PM, he stated that he removed the radio and the Febreeze machine from the SPA room.<br><br>Observations of the SPA room on 8/12/11 and 8/15/11 revealed the radio and the Febreeze machine had been removed from the SPA room. | F 323 | 1.Remove Fabreeze machine Radio from the SPAS Room immed. on 8/17/11.<br><br>2.All electric outlets in the SPA Will be grounded by 10-5-11<br><br>3.Polices & Procedures are in place to ensure no one inserts a plug in an ungrounded Outlet. 8/15/11 | |

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| F 323 | Continued From page 13<br>kitchenette on 8/11/11 at 9:00 AM revealed chemicals, including one (1) open 24 fl oz bottle of liquid sanitizer, one (1) open 24 fl oz bottle of liquid all purpose cleaner and degreaser, one (1) open 64 fl oz bottle of Miracle Bubbles, and one (1) open 25 fl oz bottle of Ivory dish soap. The chemicals were accessible in the unlocked, under the sink, cabinet.<br><br>4. Observation of the facility's first floor clean linen room on 8/10/11 at 8:45 AM revealed the door was open. Under the sink, there were three (3) 8 fl oz open bottles of nail polish remover in an unlocked cabinet.<br><br>5. Observations of the resident common SPA room on 8/11/11 at approximately 10:00 AM and 1:00 PM revealed a radio, and a Febreeze machine, sitting on a shelf above the sink flusher of urinal equipment. Both were plugged into an ungrounded electric outlet.<br><br>Observations of the resident common SPA room with E15 (Social Services Director) on 8/10/11 at 1:45 PM revealed the radio and the Febreeze machine were still in the same position as observed earlier. E15 confirmed the finding and stated she would contact maintenance. In an interview with E16 (Maintenance Director) on 8/10/11 at 3:00 PM, he stated that he removed the radio and the Febreeze machine from the SPA room.<br><br>Observations of the SPA room on 8/12/11 and 8/15/11 revealed the radio and the Febreeze machine had been removed from the SPA room.<br><br>6A. Observations on 8/12/11 and 8/15/11 of the | F 323 | F 323 #3 and #4 and #5<br>1. Corrective Action<br>Removed all items under sink in Kitchenette area of sanitizer, liquid cleaner, Miracle Bubbles, and Ivory soap; and nail polish removed from 8/17/11 cabinet in clean utility area. Radio and febreeze machine removed on 8/17/11 from SPA. No residents affected.<br>2. Identification of other Residents<br>All residents have potential to be affected.<br>3. Systems Implemented<br>Area under sink is kept free from chemicals and locked for maintenance. In-services provided to staff to assure compliance of regulations for resident's Environmental safety by 9/30/11.<br>4. Quality Assurance Monitoring<br>Weekly audits for compliance of area maintained to be locked will be done by DON/ or designee and reported at Quarterly QI. | |

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| F 323 | Continued From page 14<br>janitor closet (Housekeeping room B-21) located in the basement revealed the door to this room was unlocked with hazardous chemicals accessible to the residents. The sign on the door stated to keep the door closed.<br><br>Numerous observations were made during the survey of residents walking alone in the basement.<br><br>On 8/15/11 at 10:35 AM, the janitor closet door in the basement was observed unlocked.<br><br>6B. Observations of the first floor HC janitor closet on 8/15/11 at 11 AM revealed the door to this room was unlocked with chemicals, such as Oasis sanitizer dispensing units and bottles, which were accessible to the residents. The sign on the door stated to keep the door closed.<br><br>6C. Observation of an unidentified unlocked room storing incontinent pads, next to the laundry in the basement on 8/12/11 and 8/16/11, revealed a second door which led to a room that stored hazardous cleaning chemicals, and open cleaning carts with chemicals. Both doors were observed unlocked with chemicals accessible to residents that attended activities, physical therapy, and the beauty parlor in the basement<br><br>7. Observations were made on 8/15/11 at 9:45 AM and 10:40AM, 8/15/11 at 2:30 PM that revealed the door to the electrical room (Electrical 8-22) in the basement was unlocked and contents were accessible to residents. The door had a sign that stated, "Danger High Voltage, Keep Out", "For staff only". | F 323 | 1. All doors are locked.<br>2. There is a sign on the door stating "Doors are locked. Do not open."<br>3. Policies / procedures are in place to ensure the doors are locked.<br>4. Doors will be checked daily. 9/15/11 | |

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| F 323 | Continued From page 15<br>In an interview with E16 (Maintenance Director) on 8/15/11 at 10:40 AM, he stated that the lock was in disrepair. E18 (Maintenance staff) on 8/15/11 at 11 :30 AM and 1 :30 PM was observed working on the door lock. On 8/15/11 at 2:30 PM, E17 (Maintenance staff) stated they had to contact a lock smith to repair the door lock.<br><br>Observations were made on 8/16/11 of the door housing the high voltage electrical panels in the basement that revealed the door remained in disrepair. Observation of the door (electrical room, Electrical 8-22) on 8/17/11 at 8:00 AM with E2 (DON) revealed the door was still unlocked. E2 stated that she would talk to maintenance staff.<br><br>On 8/17/11 at 10:00 AM, the door was observed locked.<br><br>8A. Observation on 8/10/11 at 9:00 AM of the armed exit door located in the HC hallway at the end of the unit (across from room 113 and next to the clean linen room) revealed that when the door was opened by the surveyor it did not trigger the alarm. A stop sign was observed at the door.<br><br>Observation of the armed door on 8/11/11 at 10:02 AM with E13 (Unit clerk) revealed that the door did not trigger an alarm when E 13 opened the door. E13 stated, "When you open this door, the door should alarm". There was a sign indicating not to open the door as the alarm would sound.<br><br>E 13 was observed placing a key in the sentry alarm door system box above the door to determine if the door would alarm and the key | F323 | 9/15/11<br>1. American Lock & Security replaced or repaired all locks to original working state.<br><br>2. When residents walk around they will see all doors are closed and locked.<br><br>3. Policies / procedures are in place to check all doors for working order.<br><br>4. A walk-around will take place on a daily basis to ensure doors are lock.<br><br>1. Replace all batteries on all doors that have alarms.<br>2. The alarm will sound when door is open.<br>3. All batteries will be replaced every 6 mouths and dated instead of 12 months<br>4. Policies / Procedure are in place to check the alarms on a weekly basis. | |

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| F 323 | Continued From page 16 | F 323 | | |

failed to make the door alarm. The door did not alarm when opened after numerous attempts by E13 to use the key in the sentry alarm system box on the door. E13 indicated that there were two residents with Wanderguard bracelets (R10 and R22) in that wing who were flight risks and the door alarm would indicate to staff if a resident opened the door. E13 stated that the door alarm was nonfunctional.

A few minutes later on 8/11/11, the door was then tested by E8 (Nurse) with and without the key and the door did not alarm when opened as the sign indicated. In an interview on 8/11/11, E8 stated that the door was supposed to alert staff if the residents were leaving through the armed door. E8 confirmed the alarm was nonfunctional. Additionally, E8 confirmed that the facility had no system for testing the sentry II fire alarm on door.

8B. Observations of an outside exit door of the HC unit (by the elevator) from 8/11/11 through 8/17/11, revealed that the door did not sound an alarm. This door had access to the outside property and streets.

In an interview on 8/11/11 at 11:20 AM, E3 (ADON) stated that the electricity went down over the weekend due to a major storm that passed by and that this probably caused the alarm doors not to alarm. E3 stated that the doors should have been checked.

On 8/11/11 at 11:55 AM, in an interview with E16 (Maintenance Director), he revealed that the door alarms system box contained batteries which were dead and last changed about a year ago. His staff was observed changing the batteries to

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| F 323 | Continued From page 17 | F 323 | | |

the HC front door alarm system box. E16 stated that maintenance checked the batteries on these armed Sentry unit doors once/year. E16 stated that maintenance did not test the Wanderguard systems on doors but that nursing tested them. E16 confirmed that maintenance lacked a system for checking the alarm and Wanderguard doors at the facility.

In an interview on 8/11/11 at 2:45 PM, E8 (Nurse) stated that they had no system for testing the sentry II armed doors (or door across room 113).

9. Review of facility policy/procedure entitled "Elopement management" revealed that Wanderguards and alarms on exits are tested for accuracy on 3 to 11 shift by the nurse or designee.

Observation of a test done on R22's Wanderguard bracelet by E8 (Nurse) and E13 (Unit Clerk) on 8/11/11 at 2:45 PM revealed that the bracelet on the resident was nonfunctional. The Wanderguard doors were observed functioning.

In an interview with E7 (nurse) on 8/11/11 at 3:15 PM, E7 stated that they tested the Wanderguard doors and residents' Wanderguard bracelets using a testing box but did not document the door information anywhere. She stated that only R22 had a Wanderguard bracelet because R10's physician discontinued his Wanderguard bracelet on 8/10/11. E7 stated that the functioning of the Wanderguard bracelet was documented on residents' MARs.

E7 (Nurse) on 8/11/11 stated the facility had been

F 323 #9 R10 and R22

1. Corrective Action

When discovered on routine check R 22 from nurse that the resident's wander bracelet wasn't functioning; a Resident Wandering Safety Log was immediately implemented to assure remaining on the unit. on 8/11/11

2. Identification of other Residents

No other residents were assessed as High Risk for Elopement.

3. Systems Implemented

TARs to include documentation for effectiveness of the wander bracelet and system is implemented for daily monitoring (wander bracelet checked every shift by medication nurse and the system is checked daily by nurse on 11-7 shift). If not functioning it is reported immediately to unit manager or Admin. supervisor. by 9/1/11

4. Quality Assurance Monitoring

Compliance of documentation is audited weekly by the Unit Manager/ or designee for effectiveness and implemented interventions required to assure resident safety and reported quarterly at QI.

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| F 323 | Continued From page 18<br>monitoring R22 every hour beginning today when the facility tested his band and noticed it was nonfunctional. E7 stated that the facility had no additional Wanderguard bracelets in the facility. Record review for R22 revealed that the staff had a monitoring sheet that was started on 8/11/11 at 11:45AM.<br>10. On 8/15/11 at 10:50 AM, observations of one (0f three) therapy rooms during the environmental tour with E16 (Maintenance Director) revealed two oxygen tanks were unsecured on the floor. In an interview with E14 (Occupational Therapy Staff) on 8/15/11, she stated that she did not know the status of the tanks and had no crate to store them. Following the interview with E14 (Social Service Director), E16 was observed telling E14 what to do with the tanks. | F 3231 | 1. Removed oxygen tanks and stored them in 1st floor Oxygen Room. (8/17/11 removed immed.)<br>2. Policies / procedures are in place to have PT monitor all oxygen use in PT room and store in safe place. by 9/30/11<br>3. PT will ensure all oxygen is in its proper place | |
| F 329 | 483.25(1) DRUG REGIMEN IS FREE FROM SS=D UNNECESSARY DRUGS<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic | F 329 | | |

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| F 329 | Continued From page 19<br>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs when a drug was used without adequate monitoring, without adequate indications for use or without a gradual dose reduction (GDR) for an antipsychotic medication for 2 residents (R3 and R11) out of 26 Stage II sampled residents. R11 was on Xanax, an antianxiety medication administered prn (as needed) and Resperdal, an antipsychotic medication without adequate monitoring. R11 was also on Levothyroxine with an incorrect diagnosis, therefore, lacking an indication for use. For R3, there was no GDR attempted with the use of the antipsychotic medication, Klonopin. Findings include:<br><br>The facility policy/procedure for Psychotropic (Psychoactive) Drug Documentation, dated 4/07 stated, "If psychotropic drugs are administered on a PRN basis, document on the back of the medication form the number of times the PRN drug has been used during the past week, effectiveness of the drug and assessment for occurrence of side effects." | F 329 | F 329<br>#1A R11<br>1. Corrective Action<br>No Resident was affected (R11 diagnosis corrected immed. 8/11)<br>2. Identification of other Residents<br>All residents have the potential to be affected.<br>3. System Implemented<br>All new orders for Psychotropic Medication; Aims assessment implementation and new admission charts are reviewed at daily clinical meetings as received, by 9/30/11.<br>4. Quality Assurance Monitoring<br>Weekly audits will be completed on all Aims assessments and Psychotropic medication orders by the Unit manager/ or designee to assure compliance for baseline. | |

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1A. R11 was diagnosed with Alzheimer's Dementia with psychotic features. R11 was started on Resperdal, an antipsychotic medication in 6/11. However, there was no baseline assessment done for abnormal movements/AIMS.

The Psychotropic Medication use care plan, dated 6/7/11, had the goal, "Resident will remain free of drug related complications, including movement disorder, hypotension, gait disturbance, constipation or cognitive/behavior impairment."

The facility failed to determine a baseline of abnormal movements for R11.

1B. R11 was on Xanax prn, an antianxiety medication. Review of the 7/11 and 8/11 Medication Administration Records (MARs) revealed that there was no monitoring regarding the effectiveness of Xanax prn administered on 7/26/11, 7/29/11, 8/2/11, 8/9/11, and 8/12/11. Additionally, there was no documentation indicating any monitoring in the nurse's notes regarding the effectiveness of prn Xanax when it was administered for these dates.

The facility failed to monitor the effectiveness of prn Xanax use.

1C. R11 had a diagnosis of hypothyroidism and was being treated with Levothyroxine. However, review of the 8/9/11 physician order sheet incorrectly noted the diagnosis/indication for use of Levothyroxine was hyperthyroidism.

The facility failed to ensure R11's drug regimen

F 329
#1B R11
1. Corrective Action
No resident affected adversely
2. Identification of other Residents
All residents have the potential to be affected.
3. System Implemented
Policy and Procedure for PRN Medication documentation to include the use and effectiveness is in-serviced to all nurses by 9/30/11.
4. Quality Assurance Monitoring
Weekly audits will be maintained by ADON/ or designee to assure compliance of all PRN medication are supported with documentation on MAR/ nurses notes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085055 | A. BUILDING _____ B. WING _____ | 08/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MASONIC HOME OF DELAWARE | 4800 LANCASTER PIKE WILMINGTON, DE 19807 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 21 | F 329 | | |

was free from unnecessary drugs related to adequate monitoring and adequate indication for use. On 8/16/11, findings were confirmed with E2 (DON) and E3 (ADON).

2. Review of R3's clinical record revealed a diagnosis of depression with a history of psychotic episodes. R3 was on Klonopin since February 2010 without evidence that there had been an attempt at a GDR. This was confirmed with E3 (Assistant Director of Nursing) on 8/16/11.

Review of the care plan, dated 6/9/11, revealed that R3's Klonopin use was related to generalized anxiety disorder.

Review of R3's Medication Administration Record (MAR) dated 07/11 and 8/1/11 through 8/14/11 revealed that staff were not monitoring the number of episodes of anxiety for the use of Klonopin. There were no episodes of anxiety documented for this time frame.

Review of the consultant pharmacist monthly medication review, dated 6/27/11 revealed a recommendation that a GDR be completed for R3 due to her taking Klonopin for greater than six months.

Review of R3's physician's progress notes, dated 7/7/11, 7/19/11, 7/26/11and 8/2/11 revealed no response by the physician with regard to the pharmacists recommendation for a GDR for Klonopin on 6/27/11.

F 329
#1C R11

1.Corrective Action

No resident was adversely affected; immediate correction of typographic error in diagnosis was completed by Pharmacy with clinically indicated diagnosis. on 8/17/11.

2. Identification of other Residents

All residents have the potential to be affected.

3. Systems Implemented

All POS and medication orders will be reviewed for clinically indicated diagnosis' accuracy on new orders and existing orders and will be corrected if needed with daily reviews at clinical to assure accuracy on resident records by 9/30/11.

4. Quality Assurance Monitoring

Monthly audits will be performed by nurse at end of month Recapps on all POS, MAR, TARs to assure accuracy of diagnosis / medication ordered.

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| F 329 | Continued From page 22<br>During an interview with E2 (Director of Nursing) on 8/15/11, she confirmed that she review's the monthly pharmacy recommendations, then gives them to E4 (Unit Manager).<br><br>During an interview with E4 on 8/15/11, she stated that she keeps the pharmacy recommendations given to her by E2 in a folder in her office until the physician comes to the facility. After the physician reviews the pharmacy recommendations, E4 checks them to see what needs to be completed. E4 stated that R3's physician comes into the facility a couple of days a week. | F 329 | F 329<br>#2 R 3<br>1. Corrective Action<br>No resident was affected adversely<br>2. Identification of other Residents<br>All residents have the potential to be affected.<br>3. Systems Implemented<br>Dr. Durlofsky Psychiatrist was scheduled On 13 September 2011 and attended the Medication and Psychotropic Medication Reduction Meeting along with Dr. Winter and will be ongoing quarterly.<br>All Pharmacy consultant recommendations are reviewed at this time, if not already completed for the month by physicians with supportive documentation on residents records. by 9/30/11.<br>4. Quality Assurance Monitoring<br>Medication Reduction meeting notes are maintained by the Social Services Director as completed and the Unit Manager assures all interventions for GDR as recommended by the Pharmacy Consultant or Physicians are in resident records with follow through and an audit is maintained by the Unit Manager monthly and reported at quarterly QI. | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. | F 441 | | |

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| F 441 | Continued From page 23<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, review of facility documents and staff interviews, it was determined that the facility failed to follow recommended washing of soiled linen regarding water temperatures. Additionally, the facility failed to help prevent the development and transmission of disease and infection as observed by improper hand washing technique during the medication pass observation for 3 residents (R10, R16, and R21) out of 10 residents. Findings include:<br><br>The facility's Infection Control Policy and Procedure, undated, regarding "Laundry and Bedding, Soiled" was reviewed.<br><br>1. Observations on 8/15/11 at 9:50 AM of the laundry's two washer water temperatures with E16 (Maintenance Director), E17 (Maintenance Staff) and E19 (Laundry Staff) revealed the | F 441 | F 441<br>1. Corrective Action<br>No resident was affected<br>2. Identification of other Residents<br>All residents have the potential to be affected.<br>3. Systems Implemented<br>In-service education for all staff initiated for proper and effective Handwashing with review of the Policy and Procedure provided by 9/30/11.<br>4. Quality Assurance Monitoring<br>At completion of Handwashing In-service a competency will be completed by Staff Development Nurse for compliance and ongoing annually. | |

NAME OF PROVIDER OR SUPPLIER

MASONIC HOME OF DELAWARE

STREET ADDRESS. CITY, STATE, ZIP CODE

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WILMINGTON, DE 19807

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| F 441 | Continued From page 24 | F 441 | | |

temperature of the wash water to be 85 degrees and 90 degrees Fahrenheit (F) respectively, below the recommended minimum temperature of 160 degrees F. In an interview with E16 on 8/15/11 at 10:40 AM, he revealed that the washer had a water booster, ahead of the washer, that raised the temperature of the wash water to temperatures of 175 to 200 degrees Fahrenheit.

Observations of the booster hot water temperatures exiting the unit revealed the water never reached temperatures higher than 120 degrees F when the washer was in the wash cycle which required the hottest water temperatures. Interview with E16 on 8/15/11 acknowledged the temperature of the wash never reached temperatures hotter than 120 degrees F, he stated there were no logs or monitoring of the temperature of the laundry water, and the facility had no vendor reports of the wash chemical dispensing system and temperatures when they inspected the system. E 16 on 8/15/11 stated he I had to repair the booster to get the proper temperatures in the washers and would contact his chemical vendor.

In an interview with E19 and E20 (Laundry staff) on 8/15/11, they revealed the temperature of the washers were 85 degrees F when they checked the temperature on the washers, and they stated they did not monitor the washer water temperatures.

In an interview with E16 on 8/16/11 at 9:00 AM, he revealed the washer chemical vendor would be there on 8/16/11. E16 stated he wanted to get the high temperatures at the washers, rather than use the chemical route with required

F 441 ECOLAB re-set the booster to 175 degrees And we now are getting 160 to 165 degrees at the washers. All chemicals titrations are in proper

Dosage specifications per each formula to provide Clean soil free linen.

New policies / procedures are in place to check Water temps every day and log all the readings

by 9/15/11

Installed temperature gauges at each washer to ensure Correct water temp

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| F 441 | Continued From page 25<br>concentration of the chlorine with low water temperatures. He stated they would make adjustments to the booster to keep the high water temperatures at the washers.<br><br>On 8/17/11 at the exit meeting, E16 stated that their booster system was working properly and the facility would send the surveyor vendor information to show this. He stated the vendor was still making adjustments to the booster and wash chemical system, and stated he had the proper water temperatures of 150 to 155 degrees (although the recommended minimum temperature is 160 degrees F).<br>3. Review of the facility's Hand Washing policy and procedure, dated 12/06, revealed, " ...7. Use a dry disposable hand towel to turn off faucet".<br><br>On 8/15/11, during the Medication Pass observation, E5 (RN) was observed shutting off the faucet with wet paper towels she had used to dry her hands after administering medications to R10 and R21.<br><br>When the surveyor addressed these observations, E5 confirmed the findings. E5 then used the proper hand washing technique until she was again observed washing her hands after administration of medications to R16 in which E5 incorrectly shut off the faucet with wet paper towels again.<br><br>The facility failed to ensure proper hand washing technique to prevent the spread of infection. | F 441 | | |
| F 520 SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS | F 520 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 520 | Continued From page 26<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of facility documentation, it was determined that the facility failed to ensure that the Quality Assessment and Assurance (QAA) Committee was attended by the Director of Nursing (DON), a Physician designated by the facility and at least 3 other members of the facility's staff. Findings include:<br><br>During an interview on 08/16/11 at 1:50 PM, E2 (Director of Nursing-DON) stated that the QAA Committee met quarterly and consisted of the | F 520 | *F 520- 1) No residents were affected by the deficient practice.*<br><br>*F 520- 2) No other residents have the potential to be affected by the deficient practice.*<br><br>*F520- 3) We will schedule the Quarterly Quality Assurance Meetings to accommodate Medical Director's availability. In the event that she/he is unable to attend on the scheduled date we will reschedule according to their availability.* (10-13-11 first QA Scheduled)<br><br>*F520- 4) The Executive Assistant will maintain meeting minutes and sign in sheets. Copies will be forwarded to the Director of Nursing. In addition, we will have internal monthly Quality Assurance meetings and develop a Quality Assurance Policy and Procedure.* | |

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| F 520 | Continued From page 27<br>DON, Medical Director, Pharmacy, Social Service, Executive Director, and Dining Services. It was further stated that the committee met on 11/5/10, 3/15/11, 5/31/11 and 7/5/11.<br><br>Review of the attendance/sign in sheets revealed that no physician was present at the 11/5/10 and 7/5/11 meetings. The DON confirmed these findings at 2:20 PM and further stated that the facility did not have a QAA policy and procedure. | F 520 | | |

**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

**STATE SURVEY REPORT**



**NAME OF FACILITY:** Masonic Home

**DATE SURVEY COMPLETED:** August 17, 2011

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---|---|---|
| | An unannounced annual survey was conducted at this facility from August 10, 2011 through August 17, 2011. The deficiencies contained in this report are based on observations, staff interviews, review of clinical records, facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was 22. The stage 2 survey sample totaled 26 residents. | |
| **3201** | **Skilled and Intermediate Care Nursing Facilities** | |
| **3201.1.0** | **Scope** | |
| **3201.1.2** | **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross refer to the CMS 2567-L survey report date completed 8/17/11, F159, F241, F309, F318, F323, F329, F441 and F520. | |

Provider's Signature _____ Title _____ Date _____